DEPARTMENT OF THE ARMY
HEADQUARTERS, WALTER REED ARMY MEDICAL CENTER
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WRAMC Regulation
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Medical Services

USE OF PHYSICAL RESTRAINT IN THE ACUTE MEDICAL AND SURGICAL (NON-PSYCHIATRIC) ENVIRONMENT

1. History

This regulation is a revision of a previously published policy. This publication contains extensive revisions therefore the changed portions are not highlighted.

2. Applicability

a. Personnel. This regulation is applicable to personnel caring for patients in clinical settings at Walter Reed Army Medical Center, as appropriate.

b. Circumstances. Patients will ONLY be restrained when necessary in order to limit their movement as a means to protect themselves and others, including staff, from harm.

3. Purpose

This regulation provides guidance for the use of restraint in the acute medical and surgical (non-psychiatric) environments at WRAMC. This regulation ensures:

a. The primary use of restraint in a medical-surgical environment is to support medical/surgical healing.

b. The appropriate, safe, and proper use of restraint in the delivery of patient care while advocating an environment free from restraint within WRAMC.

c. All staff understand the general principles governing the use of restraint, including guidelines for implementation and documentation.

d. The use of alternatives to restraint (non-physical interventions) are maximized in order to minimize the use of restraint. (See Appendix A)

e. All clinical staff recognize that restraint use is a high-risk problem-prone procedure/process known to jeopardize the safety of patients served, and should be used *only* as a last resort.

4. References

a. Comprehensive Accreditation Manual for Hospitals (CAMH), Joint Commission on Accreditation of Healthcare Organizations (JCAHO) (Current edition).

b. Restraint and Seclusion: Complying with Joint Commission Standards, Joint Commission on the Accreditation of Healthcare Organizations (2002).

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*This regulation supercedes WRAMC Reg 40-7, dated 7 July 1999

c. Restraint: Minimizing Use, Improving Outcomes in Acute Care Hospitals, Joint Commission Resources Tape Library (September 2001).

5. Explanation of Terms

a. Restraint: Any method (chemical or physical) of restricting an individual's freedom of movement, physical activity, or normal access to his or her body.

b. Physical Restraint: Any method of physically restricting a person's freedom of movement, physical activity, or normal access to his or her body. Physical restraint may include the direct use of physical force, with or without a patient's permission, as a means of controlling physical activities to prevent the imminent risk of harming self, or others. The physical force may be human, mechanical devices, or a combination thereof.

c. Manual Restraint: Physically restraining a patient for a limited time and for a specific clinical (usually emergency) reason without the use of an ancillary device. Examples include keeping a confused patient from elopement by physically blocking them and physically holding a psychotic patient to administer medications.

d. Approved Physical Restraint Devices and Procedures:

(1) WRAMC leadership and clinical staff have selected devices that are authorized to be used as physical restraints. However, it is imperative that each patient's care be evaluated on a case-by-case basis to consider whether the implementation of such devices and procedures constitutes restraint.

(2) The ***only*** material or mechanical devices/procedures approved and currently available at WRAMC for physical restraint include (from least to most restrictive):

(a) All 4 side-rails in the **up** position with seizure pads (*if intent is to restrain*)
(b) Therapeutic holding in excess of 30 minutes.
(c) Mitts
(d) Freedom Splints
(e) Roll Belts
(f) Soft Belts
(g) Soft Limb Restraints (wrist/ankle)
(h) Sleeved Jackets
(i) Non-Locking Cuffs

(3) To provide for patient safety, no other products will be used as a physical restraint device under any circumstance. This includes, but is not limited to:

(a) The use of sheets as belts or tucked in so tightly as to restrict a patient's movement
(b) Kerlex gauze used to wrap hands or as wrist restraint devices
(c) The placement of tables in front of Geri-chairs to prevent patients from rising on their own
(d) The placement of chairs so close to a wall or table as to prevent patients from moving or rising on their own.

e. Competent Registered Nurse (RN)/Staff: Staff members who have successfully completed hospital-approved restraint training that includes the safe application of physical restraint devices, release from restraint, monitoring procedures, and alternative non-physical treatment methods to the use of restraint devices. This training must be documented annually in the staff member's competency file.

f. One to One (1:1) Observation: 1:1 nursing care requires a staff member (RN, Licensed Practical Nurse, or technician) to be with the patient at all times and no further than an arm's length away. This is to ensure safety for patients whose level of functioning and/or behavior is significantly impaired to the degree that they are a threat to themselves or others. An example of a patient requiring 1:1 nursing care is the patient placed in 4-point physical restraints.

g. Line of Sight (LOS) Observation: LOS nursing care requires a designated staff member to be no more than 10 feet away from the patient. The staff member must be able to see the patient at all times. This is to ensure patient safety and applies to patients whose level of functioning and/or behavior is impaired to the degree that they are felt to be at risk of harming themselves or others.

h. Emergent Situations: An instance in which there is an imminent risk of a patient harming himself/herself or others, when non-physical interventions are not viable; and safety issues require an immediate physical response.

i. Licensed Independent Provider (LIP):

(1) Any individual permitted by law and the organization to provide care and services without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical responsibilities or privileges.

(2) A physician who has a state medical license

(3) A resident who:

(a) Meets the state's requirement to practice medicine under the auspices of the training program,
(b) Has successfully completed the first year of post-graduate medical education,
(c) The graduate medical education program allows the resident to perform this activity, and
(d) The activity is listed in the resident's job description.

(4) A physician without a state license is mandated to obtain a co-signature by a licensed independent provider within 24 hours of the initiation of restraint.

j. Show of Force: The assembling of a minimum of 5 personnel to present en masse to the patient to demonstrate that staff is capable of controlling the patient's behavior if he/she is unable to do so. This action helps ensure a potentially hazardous struggle does not occur.

k. Episode of Restraint: A restraint episode is defined as the period of time covered by one restraint order (i.e., 24 hours for a medical-surgical patient in restraints for medical-surgical reasons).

NOTE: The following are NOT considered physical restraints:

l. Forensic: Restrictive devices used by law enforcement personnel, e.g., handcuffs used for patients in police custody.

m. Medical Immobilization:

(1) The use of a device that is a customary part of medical, dental, diagnostic, or surgical procedures that immobilizes a patient or restricts a patient's access to part(s) of his or her body and is used to promote medical healing.

Physical restraint differs from the use of medical immobilization mechanisms and practices. These procedures are considered a routine part of care and include (but are not limited to):

(a) Body restraint during surgery.
(b) Arm restraint during intravenous administration.
(c) Temporary physical restraint before administration of electroconvulsive therapy.

(2) The use of soft wrist restraints on an infant to prevent him or her from pulling or tugging on tubes and wires is included in this category. Infants and toddlers (age 0-36 months) lack the cognitive ability to be educated not to pull or remove lines and tubes. A child who has the cognitive ability below the age of 36 months due to a developmental delay will also be included in this category.

n. Protective Devices: Mechanisms intended to compensate for a specific physical deficit or prevent a deviation from safety standards resulting in injury. These mechanisms usually include protective helmets, lap belts/boards (with release devices placed where the patient can access them), bumper pads and half bed rails. Protective devices may be used without a licensed independent provider order but require observation to identify or prevent untoward or undesirable effects.

o. Adaptive Support Devices: Devices intended to permit a patient maximum normal body function through the use of restrictive devices. The devices are used to meet the assessed needs of the patient who requires adaptive support (postural). Examples of adaptive devices include orthopedic appliances, braces, and torso support devices to maintain a sitting position and side rails used to help a patient self-turn.

p. Assistive Devices: A device used to enable a patient to perform normal activities of daily living independently such as eating, drinking, reading or self-positioning in bed. Examples of these devices include geri-chairs, over-the-bed tables, and side rails with controls.

q. Therapeutic Holding/Comforting of Children: Therapeutic holding or comforting of pediatric patients, for 30 minutes or less, when its use is consistent with behavioral management standards. Note: **Therapeutic holding in excess of 30 minutes is considered to be a manual restraint.** This holding requires training that must be documented in the staff member's competency file.

r. Sedation: The use of pharmacological agents with a therapeutic intent that may result in the restriction of patient movement, normal activity, or body access.

s. Chemical Restraint: The use of pharmacological agents with no therapeutic intent as an alternative to physical restraint is termed chemical restraint. Chemical restraint is prohibited at WRAMC.

t. Seclusion: The involuntary confinement of a person in a locked room. This therapy is **NOT** authorized for use at WRAMC.

u. Time-out: Voluntary procedures used to assist individuals to regain emotional control by removing them from the immediate environment and allowing them to relax in a quiet area. A time-out exceeding 30 minutes is considered seclusion, a procedure not used at WRAMC.

6. Responsibilities

a. The Executive Committee of the Medical and Administrative Staff (ECMAS) supports initiatives created to encourage an organizational culture that emphasizes use of alternative measures to restraint and insists on maximizing patient safety should restraints be required. The ECMAS supports the leadership philosophy that mandates:

(1) Initial and ongoing education and training regarding alternatives to restraint, and the safe and proper application, monitoring, and use of physical restraints, to include criteria for device termination (See Appendix B). This training is provided to nursing staff from all shifts as well as part-time, per diem, and contract personnel, as well as allied health students, physicians, therapists, mental health workers, and others who may need to be educated and evaluated on restraint policies and procedures. Because restraint is a high-risk and problem-prone procedure/process, annual competency assessment is required.

(2) Education and training to dispel myths associated with use of physical restraint. These **MYTHS** include:

(a) Restraint protects individuals from harm and prevents falls and serious injuries, particularly among the frail and elderly.
(b) Restraint use reduces liability risks.
(c) Restraint improves an individual's posture and body positioning.
(d) Restraint calms an agitated or confused individual and hence has therapeutic value.
(e) Fewer staff members are required when restraint is used. Hence restraint use lowers staff costs.
(f) Staff feel more secure and comfortable when restraint is used.
(g) Effective alternatives to restraint do not exist.

(3) Maintaining a focus on patients' safety, rights, dignity, and well-being.

(4) Identifying and documenting of the clinical justifications for use of physical restraint.

(5) Providing patient and family education, as appropriate.

(6) Identifying and potentially preventing behaviors that lead to restraint use.

(7) Promoting preventive and alternative strategies that limit or eliminate the need for restraint.

(8) Ensuring that staffing levels and assignments in the organization minimize circumstances that give rise to the use of restraint and that they maximize safety when restraint is used. This includes the appropriate staffing level, mix, and scheduling to ensure safe patient care.

(9) Ensuring the integration of data collection and analysis into performance improvement activities because restraint use is a high-risk and problem prone procedure. (See Section 10 of this policy for PI initiatives).

b. Department Chiefs.

(1) Clinical department Chiefs will ensure all clinical staff receive annual restraint education and training to ensure their competence if restraint use is or could be an integral part of their patient care. (Documentation of training will be maintained in the competency file for all non-privileged providers).

(2) Clinical department Chiefs will ensure that each service of their department, in collaboration with nursing personnel, determines the appropriate selection and number of devices to be stocked and available for the care of their patients (not all devices and sizes are appropriate for all care areas).

c. Logistics.

(1) Stock levels: The supply technician for each floor will order and stock all appropriate physical restraint devices for patients receiving care on that floor (by specialty). All devices in all sizes need not be ordered and stocked on each floor.

(2) Laundering: Physical restraint devices are reusable except when otherwise indicated. Soiled devices will be turned in to Linen Management Branch with a completed DA Form 1974 (Laundry List, See Appendix C). Turn-around time for the laundering of restraint devices is approximately 48 hours. ***DO NOT place restraint devices in the regular laundry; they will be discarded.***

7. Policy

a. Indications for the use of restraint in an acute medical or surgical (non-psychiatric) environment directly involve supporting medical healing such as protecting a site of care on an individual's body.

b. Behavioral health reasons for the use of restraint are primarily to protect the individual against injury to self or others, including staff, because of an emotional or behavioral disorder. The individual may be receiving any type of care in the facility; the patient may not be on the psychiatric ward.

c. Restraint will be used only when alternative methods are not sufficient to prevent significant harm to the patient or others, or damage/destruction of property. It may be used in response to emergent, dangerous behavior, as an adjunct to planned care or, in some cases, as part of standard practice protocol. The decision to restrain requires adequate and appropriate clinical justification. Restraint is to be applied for no longer than is clearly needed; any doubts about the need for restraint should be resolved in favor of an alternative to restraint. *WRAMC does not permit the use of restraint for punishment, staff convenience, or in lieu of patient supervision.*

d. Patient Assessment.

(1) **Risk Assessment**: In order to plan effective alternative strategies to the use of restraint, all patients will be routinely assessed upon admission for situations that may result in danger to self or others. A comprehensive assessment will include:

(a) Mental status examination to include at a minimum, orientation and level of consciousness.
(b) Evaluation of patient's ability to understand and comply with the treatment plan.
(c) Consideration of potential for drug or alcohol withdrawal.
(d) Evaluation of drugs or illnesses that could alter mental status.
(e) Identification of irritating dressings, tubes or lines.
(f) Analysis of self-care deficits that could result in injury.
(g) Analysis of oxygenation, comfort, ability to rest and environmental factors.

(2) Criteria for the use of Restraints: (**Clinical Justification**). Restraint will be used only when alternative strategies have proven ineffective and the patient demonstrates any of the following behaviors:

(a) Removing dressing, lines, devices, or tubes deemed medically necessary.
(b) Ambulating without assistance when at risk for falls, when self-injury may result due to non-weight bearing status or the patient climbing over the side-rails, or when mental status is such that the patient is disoriented, and is likely to wander and become lost or leave the WRAMC campus.
(c) Display of assaultive, combative, or destructive behavior.
(d) Attempts to harm self, others, or damage property.

e. Requirements. All incidents of restraint must adhere to the following:

(1) Assessment, monitoring, application, management, and removal of restraints will be accomplished by staff who have completed competency-based education and training for the use of physical restraints. ***ONLY*** an RN or a licensed independent provider (LIP) will make the initial decision to apply and the ultimate decision to terminate the use of a restraint. The RN and/or LIP will complete the initial documentation (restraint note) for the placement of the physical restraint device.

(2) Restraints ***will ONLY be used when alternative (less restrictive) techniques have failed.*** Alternative therapies to the use of physical restraint will be clearly documented in the medical record daily. The need for all devices will be reassessed, at a minimum, every 2 hours, and removed as soon as possible.

(3) Patient rights, dignity, safety, and physical and emotional well-being will be preserved.

(4) Use of restraints will be based on an individual patient's assessed needs. Restraint use will be limited to **clinically justified** situations.

(5) When a physical restraint device is clinically justified, the RN or LIP will determine and use the least restrictive device.

(6) The patient's physical and emotional needs are continuously reassessed and addressed throughout the period of physical restraint use.

(7) The patient/family is educated and involved in the decision process for the use of restraint when practical and appropriate.

(8) Care throughout the restraint episode must be clearly documented in the medical record. (See Documentation in Section 9 of this policy).

8. **Procedures**
The procedures associated with the use of restraint apply to each patient placed in restraint and to each episode of restraint use.

a**. General Guidelines for Use of Restraint in a Medical-Surgical Environment**
(Includes all wards and critical care units.)

(1) LIPs will:

(a) Conduct **Face-to-Face assessment** of patient.

(b) Ensure all **preventive strategies and alternative measures** have been exhausted.

(c) Determine and document **Clinical Justification** for the use of physical restraint in the CIS WR Restraint Note. See paragraph 7.d (2) for the criteria for the use of physical restraint.

(d) **Write orders** for the use of restraints. A set of templated orders are located in the "standard orders" of CIS. Orders for restraint must be time-limited; therefore the templated orders located in CIS are defaulted to automatically expire in 24 hours. All four (4) orders of the order set **MUST** be initiated for each restraint episode. Once the 4-order set is opened, use the **"Assign all"** function key at the bottom of the CIS screen to activate all 4 orders at one time. The four orders are as follows:

(i) Restraints, Q8 hr x 3. (This is a time-limited order that expires in 24 hours.)
(ii) Notify H.O. if deterioration in patient's condition Q-shift.
(iii) Provide patient and family education (x1). Explain the rationale for the use of restraint.
(iv) Restraint Monitoring Q2 hours.

(e) **Continued use** of restraints beyond the first 24-hours can only be authorized by a licensed independent provider **renewing** the original order or **issuing a new order** if the use of restraints remains clinically justified. Renewal orders or new orders are issued no less than every 24 hours and are based on a physical assessment/examination of the patient by the LIP/physician. **PRN** and/or **Continuous orders** are **NOT** acceptable at any time for physical restraint use.

(f) Complete documentation of the restraint episode in the **WR Restraint Note** located in CIS. Completion of all fields in the note will document the following:

(i) events leading to the restraint episode,
(ii) alternative measures attempted,
(iii) whether event was initiated by an RN (emergency) or ordered by a physician,
(iv) delineate the least restrictive device to be used, and
(v) provide documentation of the patient and family education, as appropriate.

(2) RNs will:

(a) Conduct patient **assessment**.

(b) Ensure all **preventive strategies and alternative measures** have been exhausted

(c) **Notify LIP** to obtain a time-limited **order** for physical restraint which cannot exceed 24 hours. If LIP is unavailable, an RN **may initiate** the use of a physical restraint based on an appropriate assessment of the patient. In this circumstance, a LIP will be notified within 12-hours of the initiation of restraint and a telephonic or written order will be obtained from the physician and entered into the patient's medical record.

NOTE: A written order, based on an examination of the patient by a LIP must be entered into the patient's medical record within 24 hours of the initiation of restraints.

(d) It is important to note, the RN must notify the LIP *immediately and obtain an order for restraint* if a significant change in a patient's condition indicates the immediate need for restraint.

(e) **Apply appropriate device**.

(f) **Educate** the patient and family, as appropriate.

(g) **Conduct ongoing monitoring**. It is essential to continuously assess and reassess the restrained patient to prevent harm, ensure the protection of patient's rights, and prevent feelings of isolation or despair. The goal is to continuously validate the continued need for restraint and to terminate the use of restraint as soon as safely possible.

(h) Monitor by observation, interaction with the patient, or related direct examination of the patient by qualified staff. Ensure that the patient's dignity and rights are protected; and to prevent injury, reassess and document the patient's status no less than every **2 hours** using the **CIS Protective Device Assessment Screen** (flowsheet)**.** Minimal nursing interventions provided and documented include seven key areas:

(i) Offering fluids/hydration, when appropriate.
(ii) Providing nutrition.
(iii) Conducting skin and circulation checks.
(iv) Releasing each device and repositioning.
(v) Conducting ROM/Skin care.
(vi) Offering/ensuring elimination needs are met.
(vii) Behavior/status: determine need to continue use of restraint, assess orientation.

(i) Patients placed in **4-point** restraints require special care and monitoring at **15 minute** intervals. This patient also requires **1 to 1 observation**. Documentation of the ongoing monitoring will be done every 15 minutes.

(j) If the restraint is terminated early, before the physician order expires, the order may be used again if the same behavior(s) reoccur within the time frame covered by the physician's initial order. If the need for restraint recurs, but is due to a different reason than the original order, a new order must be obtained.

b**. Care of the Behavioral Health Patient requiring Physical Restraint in the Acute Medical or Surgical (non-psychiatric) Environment.** Behavioral health care patients receiving care in a medical or surgical environment and who require the use of restraint devices for a behavioral (psychiatric) health indication, rather than a medical indication, will be treated as follows. (This policy is in accordance with the WRAMC policy for the Use of Restraint in a Behavioral Health Environment).

NOTE: Authorization for the use of restraint (in this population) is limited to **Emergencies ONLY** utilizing 4 point restraints with non-locking cuffs. Nonphysical techniques are always considered as the preferred intervention. Restraint is employed only when non-physical interventions are ineffective or not viable and when there is imminent risk of harm to the patient or others.

RNs or LIPs will determine the least restrictive method to manage individual patient behavioral problems. The least restrictive, safe and effective therapy/treatment appropriate to the patient's behavior will be used.

(1) LIPs responsibilities:

(a) Conduct a **face-to-face assessment**.

(b) Order the use of physical restraints by initiating/ordering the CIS "**Restraint Orders Behavioral Health**" order set selecting the order set by the age of the patient (see subparagraph (d) below). All orders of the order set MUST be activated and are ordered by clicking the "assign all" key at the bottom of the CIS screen.

(c) Because physical restraints are used only in an emergency situation, a nurse may initiate their use. However, the LIP must be notified immediately of the restraint episode. The LIP must conduct a face-to-face assessment of the patient within **one hour** of the initiation of restraint. During this assessment, the LIP validates the clinical necessity for the continued use of the physical restraint and subsequently provides written orders within **one hour** of the initiation of restraints. **Verbal orders** and **telephonic orders** are acceptable if the physician cannot immediately report to the patient's bedside (but the face-to-face assessment must be done within 1-hour).

(d) Restraint orders must be time-limited. Limits in the behavioral health care setting are set at **four hours for patients age 18 and older.**

(e) The 6 orders are as follows: (mandatory requirements).

(i) Place patient on 1:1 watch.
(ii) Delineate of the type of restraint device to be utilized.
(iii) Time-limited event: Each order for physical restraint must have a specific start and stop time.
(iv) Patient Education: Family involvement and notification when appropriate.
(v) Vital signs every 4 hours while in restraint.
(vi) Call the Psychiatrist on Duty for any changes in condition (not including discontinuation of restraint episode).

NOTE: **"PRN"** and **"continuous"** orders will ***NEVER*** be used.

(f) Continued use of restraints beyond the first 4 hours is authorized after conducting a reassessment by appropriately trained staff (RN or LIP). The LIP will provide an order, either written or telephonic, to continue the current therapy for an additional 4 hours. The physician ***MUST*** reassess the patient in person no less than every 8 hours for a patient. The interim face to face assessments may be conducted by a RN.

(g) Complete the **WR Restraint Note** in CIS documenting the **clinical justification** for the restraint episode, all **alternative measures attempted**, the **device to be employed**, and any patient or family **education** conducted.

(2) RNs responsibilities:

(a) Conduct patient assessment to include vital signs, hygiene needs, and signs of injury.

(b) Ensure all preventive strategies and alternative measures have been exhausted.

(c) Initiate the use of a proper device.

(d) Notify and obtain an order (verbal or written) from the LIP within **one hour** of the restraint episode.

(e) Educate the patient and family, as appropriate.

(f) Conduct monitoring. It is essential to continuously assess and reassess the restrained patient to prevent harm and ensure the protection of patient's rights. The goal is to continuously validate the continued need for restraint and to ensure patient safety.

(g) Monitor and assess all **4-point** restraint episodes every 15 minutes and document on the CIS protective device assessment screen. All other devices employed require monitoring and assessment every 2 hours. This assessment includes, as appropriate to the type of restraint employed:

(i) Type of device and number of limbs restrained.
(ii) Restraint-associated injury.
(iii) Skin and circulation checks.
(iv) Behavior and current mental status.
(v) Orientation (alert and oriented X 1,2,3, & 4).
(vi) Readiness for restraint discontinuation.
(vii) Nutrition/hydration offered.

(viii) Release of devices and repositioning one limb at a time.
(ix) ROM/Skin care at device sites.
(x) Hygiene and elimination needs met.
(xi) The RN may terminate the use of restraint before the time limit of the physician order, when use is no longer clinically indicated (i.e., as soon as the patient's behavior is under control and the patient is able to cooperate with health care providers). Termination or an early trial of termination of restraint use is strongly encouraged.

c. Reapplication of Restraint within the original time limit: The RN may reapply restraints if indicated using the original order if the same behavior recurs within the original time limit of the order.

d. **Transfer/Transport.** When a patient in physical restraints is transferred/transported, the **devices will be removed** upon transfer of care (arrival at facility) to the receiving facility. An annotation of the aforementioned will be made in the transfer note. All devices will be returned to the sending unit or ward.

e**. Care of the Emergency Department (ED) Patient requiring restraint.** Patients whose care requires the use of restraints in the ED can be either Behavioral Health Care patients receiving care in a non-behavioral health care setting, or medical patients needing restraints for the safety of themselves or others. Personnel providing care to the Behavioral Health Care patient receiving care in the ED will follow policies and procedures delineated above. For patients requiring restraint as part of a medical therapeutic regimen, the ED will implement care as stated in paragraph 8a of this policy. Documentation of care will be on WRAMC OP 617/618 (See Appendix D & E) as appropriate.

9. Documentation

a. The following documentation will be completed daily, by the physician, and serve as adjunct documentation to, and correspond with, the actual order set authorizing the use of restraint and will be documented in the CIS WR Restraint Note for each episode of restraint:

(1) Events leading to the initiation of restraint.

(2) All alternatives attempted prior to instituting the use of restraint.

(3) Clinical Justification for the use of Restraint.

(4) Delineation of the type of physical restraint device (using the least restrictive).

(5) Education of the patient and family, if appropriate.

b. Ongoing monitoring of the patient in restraint will be conducted every 2 hours (every 15 minutes for the patient in 4-point restraint) and documented in the Protective Device Assessment screens/note by the nursing staff.

c. Use of Overprint 617 (behavioral health) and 618 (medical-surgical) will be used in all areas without CIS (i.e.: the Emergency Department) and during times when the CIS computer system is unavailable.

10. Reporting

a. The 24 Hour Nursing Report will include the number of restraint episodes during that shift. If a patient was restrained more than once, the number of restraint episodes for that patient will be annotated.

A restraint episode is defined as the period of time covered by one restraint order (i.e., 24 hours for a medical-surgical patient in restraints for medical-surgical reasons).

b. The Night Supervisor will tally and report the total number of restraint episodes for the past 24 hours for each nursing care ward and unit.

11. Performance Improvement

a. The WRAMC's Performance Improvement (PI) Office will be responsible for implementing organizational policy for the use of restraint. The PI Office will evaluate the outcome of restraint use and report to the Quality Outcomes Committee (QOC) on a quarterly basis. Recommendation for action, based on the results of data analysis, will be determined by the members of the QOC. A summary report will be forwarded to the Governing Body at least annually.

b. Upon publication and implementation of this regulation, all episodes of restraint (100%) will be reported, documented (monitoring tool), and analyzed for a minimum of six (6) months. Collection of concurrent monitoring data and subsequent aggregation of the data will be conducted through the Facility and Department of Nursing PI offices. Patient care unit staff will complete the daily monitoring tool of the restraint episode to (1) ensure patient safety, (2) ensure compliance with restraint policy and procedures, and (3) provide accurate data on each restraint episode to the PI office.

c. Following the first report to the Governing Body after implementation of this regulation, the PI Office, in collaboration with the Governing Body, will determine if a more focused study and approach to the evaluation of restraint use is appropriate. Failure of the Governing Body to publish "in the absence of" changes to this regulation constitutes a continuance by the Governing Body of the regulation as delineated in paragraph (b) above.

d. The Chief, Nursing Performance Improvement will oversee the design and implementation of a data-collection tool for the assessment and evaluation of each episode of restraint. The goal of the process is to understand why restraint is used so that interventions can be developed in order to reduce use, as appropriate. Data collection will include, but is not limited to the following.

(1) The length of time of each restraint use.

(2) Staff who initiated the process.

(3) The length of each episode.

(4) Date and time each episode was initiated.

(5) Day of the week each episode was initiated.

(6) Clinical justification and alternatives considered.

(7) Ordered by LIP (4 order set).

(8) The type of restraint used.

(9) Injuries sustained by the patient or staff during placement of the restraint device.

(10) Patient's age.

(11) Patient's gender.

(12) Patients unit or ward.

(13) Number of episodes.

e. Unit Managers, in collaboration with the medical director, are responsible for and will provide oversee the use of restraint on their respective units. Unit managers will ensure ongoing (concurrent) monitoring for compliance with policies and to assure patient safety. Intervention will be immediate to correct any variation from this regulation in all episodes of restraint use. Restraints will never be used in lieu of adequate and appropriate staffing.

f. To ensure thorough and accurate data collection, each episode of restraint requires the completion of a **WRAMC Form 1811**, Report of Unusual Occurrence. This form will be completed at the time each order is written and immediately forwarded to the Risk Management office.

g. All episodes of restraint will be documented on the 24-hour Nursing Report (total number of restraint episodes every 24 hours). The total number of restraint episodes for each patient will be tracked throughout his/her hospitalization.

12. Education

a. Clinical Departments Chiefs will ensure all appropriate personnel receive initial training during orientation and ongoing education and training annually on all aspects of the use of restraint (alternatives, clinical justification, application, monitoring, and termination) as appropriate.

b. Competency training for nursing personnel will follow orientation (initial education) and occur on the individual nursing units.

c. Training on appropriate actions during emergent situations (including notifying nursing and medical staff) will be provided to non-clinical staff.

APPENDIX A
Preventive Strategies and Alternatives to Physical Restraint.

Implementing the following actions and strategies may reduce or actually prevent the need for restraint:

1. Provide a thorough orientation, including patient and family education, regarding the nursing unit and the plan of care. Provide each patient/family a copy of WRAMC Pam 40-93, When Restraints May be Needed; Considerations for Patients and Families (See Appendix F). Identify specific behaviors that may lead to the need for restraint and describe how the patient/family can contribute to the avoidance of restraint.

2. Increase frequency of nursing rounds.

3. Place patient close to the nurse's station.

4. Have the patient's family, significant other, and/or friends stay with the patient.

5. Use of personal alarm, tabletop chair, and/or wheelchair lap belt.

6. Provide diversional activities such as:
   (a) Giving the patient a safe object to handle.
   (b) Television.
   (c) Patient's favorite music.

7. Cover IV sites with fabric such as surginet/Kerlex.

8. Cover PEG tube with an abdominal binder.

9. Collaborate with the LIP to:
   (a) Discontinue tubes, lines, and devices when medically possible.
   (b) Request tube feedings be changed to bolus when medically possible.

10. Offer toileting at least every 2 hours and as needed when restless and assure the bowel program has been effective. Assist patient while in the bathroom or on the bedside commode.

11. Offer additional baths or showers. Assist patient with walking and/or a wheelchair ride in the hallway.

12. Position the patient in a wheelchair in the hallway with others for socialization.

13. Approach patient in a calm, unhurried manner. Reorient the patient as appropriate. Leave a dim light on at night.

14. Utilize speech therapy's recommendations in communication with patient as appropriate.

15. Ensure frequently needed items (i.e. urinal, phone, water, etc) are located on the unaffected side of a Cerebral Vascular Accident patient.

16. Psychotropic medication (routine and prn) as indicated to decrease anxiety and agitation.

17. Assess any changes in patient's physical condition that may contribute to the need for restraints. (e.g., hypoxia, electrolyte imbalance, pain).

APPENDIX B
Criteria for the Termination of Physical Restraint

When an alternative is available and/or the patient's behavior demonstrates no risk to him/herself or others, the restraint will be removed. The following criteria may be used:

1. Improved mental status.

2. No interferences with medical devices, tubes, or dressings.

3. Medical devices, tubes, and dressings have been removed.

4. Follows verbal commands.

APPENDIX C
DA Form 1974 (Laundry List)

LAUNDRY LIST (MEDICAL TREATMENT FACILITY AND ORGANIZATION) For use of this form, see AR 210-130; the proponent agency is DCSLOG			DATE
FROM *(Organization)*		TEL EXT	TOTAL PIECES

QTY	ARTICLE	QTY	ARTICLE
	Apron		Napkin
	Bag, barrack or duffel		Pad, Bed
	Bag, laundry		Pants, pajama
	Bag, sleeping		Pantsuit, top
	Bathrobe, adult		Pantsuit, bottom
	Bathrobe, infant		Pillow
	Blanket, cotton		Pillowcase
	Blanket, crib		Parka
	Blanket, wool		Rag, (lb)
	Cap, food handler		Sheet, bed
	Cap, field		Sheet, fitted
	Case, bag, sleeping		Shirt, scrub, OR
	Cloth, wash		Shirt, sweat
	Coat, convalescent		Shirt, wool
	Coat, food handler		Shirt, utility
	Coat, pajama		Shoes, canvas
	Coat, operating		Shoes, athletic
	Coveralls		Smock, physician
	Cover, mattress		Socks, (pr)
	Cover, mayo		Spread, bed
	Cover, helmet		Tablecloth, lg
	Curtains, shower		Tablecloth, sm
	Drapes (sq. yd.)		Towel, bath
	Drapes, tie (pr)		Towel, hand
	Drawers		Trousers, field
	Dress, hospital, white		Trousers, food handler
	Gloves, (pr)		Trousers, OR, green
	Gown, operating		Trousers, sweat
	Garment, surgical		Trousers, poly, wh
	Hood		Trousers, utility
	Jacket, field		Uniform, nurse
	Liner, jacket		Undershirt
	Mat, bath		Wrapper
	Mop		
FOR THE LAUNDRY		FOR THE ORGANIZATION	
SIGNATURE *(Receiver)*		SIGNATURE *(Delivered by)*	
SIGNATURE *(Shipper)*		SIGNATURE *(Pickup by)*	

DA FORM 1974, JUN 86 EDITION OF OCT 79 IS OBSOLETE USAPPC V2.00

APPENDIX D
WRAMC Pam 40-93 Restraint Brochure (Trifold)

You need to know...

When the decision to use a restraint is being considered (or must be made in case of an emergency), the staff will make every effort to inform you as soon as possible in order to discuss the reasons, the alternatives considered, and to seek other possible strategies with you to help keep the patient as safe and comfortable as possible.

We encourage ongoing discussions of your concerns. Please feel free to consult with the doctor or nurse caring for you-family member if you have concerns or questions.

The Patient Representative is also available by calling

202.782.6866

Walter Reed Army Medical Center is committed to providing comprehensive healthcare with a caring, competent staff. We respect our patients, recognize their personal preferences and values, and strive to protect their dignity.

The proponent agency of this pamphlet is the Walter Reed Army Medical Center Performance Improvement Office. Users are invited to send suggestions and comments on DA Form 2028 (Recommended Changes to Publications and Blank Forms) to Commander, WRAMC, ATTN: Performance Improvement Office, MCHL-N Washington , DC 20307-5001

FOR THE COMMANDER:

OFFICIAL: JAMES R. GREENWOOD
COL, MS
Deputy Commander for Administration

ERIK J. GLOVER
MAJ, MS
Executive Officer

DISTRIBUTION:
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Walter Reed Army Medical Center

WRAMC Pam 40-93

01 June 2002

Walter Reed Army Medical Center

When Restraints may Be Needed in the Health Care Setting

Considerations for patients and family

6900 Georgia Ave., NW
Washington , DC

WRAMC Pam 40-93

Alternatives to restraints...

It is the goal of Walter Reed Army Medical Center to provide all patients with a safe hospitalization experience. The staff are committed to protecting the rights, dignity and safety of each patient.

You may be wondering...

Patients who have been alert and oriented at home may become confused and unable to cooperate with their care and treatment while in the hospital. This change may be caused by medical or psychiatric illness, surgical procedures, unfamiliar surroundings, a change in daily routine or sleep patterns, or medication.

Occasionally, the result is behavior which poses serious risk to the person's safety or that of others in the immediate environment.

The care givers are competent to manage these temporary situations on a regular basis. Staff members may need only to provide reassurances or explanations, closer observation, diversional activities, counseling, quiet time, or attention to needs for comfort and rest. In more serious situations, changes in medications, treatment or the use of special equipment such as mitts may be necessary to keep the patient safe.

How friends and family can help...

Often the support of a familiar person can be beneficial in calming an anxious or confused person, and helping the patient to rest, recuperate and regain a normal state of health and functioning. Also, the knowledge and availability of loved ones can be an important resource to the health care team in maintaining safety. The staff members may talk about the possibilities of family or friends:

* Spending extra time with the patient on the telephone or during visiting hours when possible.

* Offering suggestions for continuing safety and comfort.

* Helping patients understand their condition, situation and the need for compliance with treatment.

Please discuss your ideas and suggestions with the nurses.

If alternatives are not satisfactory...

In some cases, the alternatives discussed above are not sufficient to keep the patient or others around them safe. If the behavior demonstrates significant danger of the patient harming him/herself, someone else, or seriously interfering with his/her treatment (e.g., pulling at tubes or lines which could result in serious injury if removed) a restraining device may be needed to maintain safety.

These devices may include belts, jackets, soft wrist restraints or four point non locking cuffs. In all cases, the least restrictive device possible will be used. You should also know that these devices may only be used with the advice and approval of the physician.

During the period when such devices are in use, staff members will continually reassess their necessity and discontinue or change to a less restrictive method as soon as possible.

Special Care will be given...

While a person requires restraints, the nursing staff recognizes that they have special responsibilities to provide care, comfort, emotional support and attention to such needs as fluids, nourishment, use of the toilet or bedpan, and changes in position. An individual in restraints is observed very closely by the staff. The person's needs are attended to with concern for their comfort, privacy and dignity.

Walter Reed Army Medical Center

APPENDIX E
WRAMC OP 617: Care of the Behavioral Health Patient in Restraint

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE: INPATIENT PSYCHIATRY RESTRAINT ORDERS AND FLOW SHEET

OTSG APPROVED (Date)

Restraint Order Note: Restraint order is for 4 hours. May be renewed x1 by RN after assessment

Start time: _____ Good until: _____ Renewed at: _____ Good until: _____ DC'd at: _____

Alternative Measures:

- ☐ Verbal de-escalation
- ☐ Soothing non-threatening voice
- ☐ Relaxation techniques
- ☐ Simple concrete statements
- ☐ Attentive listening
- ☐ Manage adverse drug reactions
- ☐ Offer regular toileting
- ☐ Family/SO participation
- ☐ Modification of environment
- ☐ Eliminate irritating tubes
- ☐ Reduce stimuli
- ☐ Closer observation
- ☐ Offer food/beverage
- ☐ Supervised physical activity
- ☐ PT/OT consult
- ☐ PRN pharmacological intervention
- ☐ Optimize physiologic function
- ☐ Improve oxygenation
- ☐ Treat infection
- ☐ Minimize sleep deprivation
- ☐ Manage drug/ETOH withdrawal
- ☐ Control Pain
- ☐ Diversional activities

SIGNATURE of Registered Nurse (if RN initiated): _____

SIGNATURE of Ordering Physician (PGY-2 or higher): _____

SIGNATURE of renewing RN: _____ DATE/TIME: _____

Clinical Justification:

- ☐ Removes dressings, lines, or tubes
- ☐ Attempts to harm self/others/property
- ☐ Wandering, climbing over side rails
- ☐ Other dangerous behavior not otherwise controlled

Modalities/Device:

- ☐ Gap Protectors
- ☐ Torso Support
- ☐ Non-Slip Matting
- ☐ Quick release limb holders
- ☐ Freedom Splint
- ☐ Mitts
- ☐ Roll Belt
- ☐ Soft Belt
- ☐ Sleeved Jacket
- ☐ 4pt Non-Locking Cuffs

Date / Hour	q15 min checks 0	15	30	45	q15 min circ. checks 0	15	30	45	ROM q1hr	Assess Elim. q1hr	Offer Fluids q1hr	Offer Food q1hr	Bath q day	VS q4hr	Pt education, response, behavior VS, and other comments

(Continue on reverse)

PREPARED BY (Signature & Title) | DEPARTMENT/SERVICE/CLINIC | DATE

PATIENT'S IDENTIFICATION (For typed or written entries give: Name – last, first, middle; grade; date; hospital or medical facility)

- ☐ HISTORY/PHYSICAL
- ☒ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER (Specify)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

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MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE: MED-SURG RESTRAINT ORDERS AND FLOW SHEET

OTSG APPROVED (Date)

Restraint Order NOTE: Restraint order must be time limited, refelect modiality, and not exceed 24 hours.

Start Time:_____ Stop Time:_____ Duration:_____

Alternative Measures:

( ) Verbal de-escalation
( ) Soothing non-threatening voice
( ) Relaxation techniques
( ) Simple concrete statements
( ) Attentive listening

( ) Modification of environment
( ) Eliminate irritating tubes
( ) Reduce stimuli
( ) Closer observation
( ) BSC/Call Bell accessible
( ) Offer food/beverage

( ) Optimize physiologic function
( ) Improve oxygenation
( ) Treat infection
( ) Minimize sleep deprivation
( ) Control pain
( ) Manage drug/alcohol withdrawal
( ) Manage adverse drug reactions

( ) Family/Significant other participation
( ) Encourage family visits
( ) RCV companion

( ) Supervised physical activity
( ) Offer regular toileting
( ) PT/OT consult
( ) Diversional activity

( ) Sedation

SIGNATURE of Registered Nurse (if order was taken as a verbal/telephonic order): _____

SIGNATURE of Ordering Physician (must be signed within 12 hours of restraint initiation): _____

Clinical Justification:

( ) Removes dressings, lines, and tubes
( ) Attempts to harm self/others/property
( ) Wandering, climbing over siderails
( ) Assaultive, Combative, Destructive behavior

Modalities:

( ) Gap Protectors
( ) Torso Support
( ) Non-Slip Matting
( ) Personal Alarm
( ) Freedom Splint

( ) Mitts
( ) Roll Belt
( ) Soft Belt
( ) Quick Release Limb Holders
( ) Sleeved Jacket

( ) Non-Locking Cuffs
( ) Ankle
( ) Wrist
( ) Right
( ) Left

Monitoring Flowsheet: Initial for care in columns below; Restraints in the Med-Surg setting require care q2 hours.
Explanation given to: ( ) patient ( ) family ( ) deferred

Date / Hour	q15 min checks[2] 0	15	30	45	Circ Checks q2 hour[2] 0	15	30	45	Rotate Restraint q2h[4] (limb)	ROM q2h[3] (4 point)	Assess Elimination q2h[3]	Offer Fluids q2h[3]	Meals, Snacks, etc. q4h[5]	Bath qd	Assess restraint need q4h	Call bell in reach q2h[4]	Pt response, behavior, condition, or other comments

[2] patients in 4 point restraints require circulationchecks q15 min for the first hour and then q2hrs if stable; q15 checks may also apply to patients restrained I inpatient psychiaty units - see inpatient psychiatry SOP

[3] while awake

[4] if appropriate (i.e. not while in 4 point restraints or on 1:1 watch)

(Continue on reverse)

PREPARED BY (Signature & Title) | DEPARTMENT/SERVICE/CLINIC | DATE

PATIENT'S IDENTIFICATION (For typed or written entries give: Name – last, first, middle; grade; date; hospital or medical facility)

☐ HISTORY/PHYSICAL ☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)
☐ DIAGNOSTIC STUDIES
☐ TREATMENT

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The proponent agency of this publication the Directorate, Performance Improvement/Risk Management Office. Users are invited to send suggestions and comments on DA Form 2028 (Recommended Changes to Publications and Blank Forms) to Commander, Walter Reed Army Medical Center, ATTN: MCHL-MAO-PI, 6900 Georgia Avenue, N.W., Washington, DC 20307-5001

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